University Hospitals

# Authorization For Release of Medical Information

| Today's Date |
|---|
| |

| | |
|---|---|
| Patient Name: | Date of office visit: |
| DOB: Age: Sex: | Occupation: |
| Address: | Home phone: |
| City: | Cell phone: |
| State: Zip Code: | Primary Care Physician: |
| E-mail: | MRN: |

SSN (last four digits) _____ Prior MRN: _____

**Please Release Medical Information to the Following Recipient:**

Name of Person or Organization: _____ Phone #: _____

Address: _____ Mailstop: _____

_____ Fax #: _____

City, State, Zip

Purpose of Disclosure: _____

☐ at the patient's request

**Description of Information to be Released:**

☐ Pertinent Summary (includes all * items)

| | | | |
|---|---|---|---|
| ☐ Admission Form | ☐*Consultation Report | ☐*Radiology Report | ☐ Physical Therapy |
| ☐*Discharge Summary | ☐*Operative Report | ☐*EKG Report | ☐ Entire Record |
| ☐*Emergency Room Report | ☐ Facesheet/Demographics | ☐*Pathology Report | ☐ Physician Notes |
| ☐*History & Physical | ☐ Lab Reports | ☐*Cardiac Cath Report | ☐ Other |

*I, the undersigned, authorize _____(Disclosing Institution) and its employees to release Information from my medical records as described above. I understand and acknowledge that the medical record may contain Information regarding psychiatric disorders, Human Immune Virus (HIV) test results, Acquired Immune Deficiency Syndrome (AIDS), AIDS-related conditions, alcohol, and/or drug dependence/abuse. I also understand that Information used or disclosed according to this authorization may be subject to redisclosure by the recipient and may no longer be protected. My failure to sign this authorization may result in my Information not being released.*

*I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:_____. If I fail to specify an expiration date, event or condition, this authorization will expire in one year.*

*I understand that treatment, payment, enrollment, or eligibility for benefits will not be conditioned on my failure to sign this authorization.*

_____ _____ / _____ / _____

Signature of Patient/Legal Representative** Date Signed

*I understand there may be charges for the copying and release of information and accept financial responsibility.*

_____

Description of Legal Representative's Authority to Act on Behalf of Patient (if applicable) ☐ Patient unable to sign

☐ By signing this form as the patient's legal representative, I am certifying that there is no court order or other legal reason (such as a binding arbitration decision or final mediation agreement) prohibiting me from obtaining a copy of the requested records.

*This box must be checked for ALL releases of records authorized by legal representatives.*

** If other than patient's signature, a copy of legal documents MUST accompany the authorization when presented; the exception is a parent of minors under 18 years of age.

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# Authorization For Release of Medical Information

You have requested an electronic copy of your records

Description of Information to be Released*:

- ☐ All (check here for all items listed below)
- ☐ Allergies
- ☐ Family History
- ☐ Immunizations
- ☐ Medications (Current and Historic)
- ☐ Past Medical History (does not include office notes)
- ☐ Past Surgical History
- ☐ Social History
- ☐ Problems (Active and Resolved)
- ☐ Results (Labs and Rad)
- ☐ Vitals

*Please be aware that these are the only documents that you can receive in an electronic download at this time.

*Signature on page 1 of Authorization for Release of Medical Information signifies I understand the preceding information is all that will be included of my Medical Records*